

## CERTIFICATE OF DEATH

Reg. Dist. No.

13158

13172

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>10 HRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>Riley</b> Last <b>ALDERTON</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 19, 1902</b>
9. AGE (In years last birthday) <b>57</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired distributor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale liquor</b>	
11. BIRTHPLACE (State or foreign country) <b>GORMANIA, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALVEY ALDERTON</b>		14. MOTHER'S MAIDEN NAME <b>ALICE TWIGG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>12/22/59</b> to <b>12/23/59</b> , 19____, that I last saw the deceased alive on <b>12/22/59</b> , and that death occurred at <b>7:20 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. Williams</b> M.D.		ADDRESS (Street, city or town, state) <b>Cumberland</b> DATE SIGNED <b>12/23/59</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS M.D.</b>		122 So. Centre St.,	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. George</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13152

CENTRAL HOSPITAL

ALLEGANY

MARYLAND

ALLEGANY

COLUMBIAN

10 HES.

GENERAL HOSPITAL & WARREN AVE.

BEVERLY ROAD

WALTER

ALBERTON

DECEMBER

29

JUNE 10, 1903

WHITE

MALE

100 WEST HES. ALLEGANY COUNTY, W. VA.

U.S.A.

ALICE WISE

ALICE WISE

GENERAL HOSPITAL

COLUMBIAN, MD.

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*

RICHARD J. WILLIAMS, M.D.  
1111 1/2 N. 1st St. CINCINNATI, OHIO

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

13173

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>6 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>S.</b> Last <b>ATHEY</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 28, 1905</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gasoline Service Station Self Emp.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CUMBERLAND, MARYLAND</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>GEORGE ATHEY</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE HINKLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-16-7131</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Sigmoid Colon</b> DUE TO <b>Generalized metastasis with Cachexia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>and intestinal obstruction</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>Approx 1 1/2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) <b>CUMBERLAND</b>			20g. (County) <b>ALLEGANY</b>		20h. (State) <b>MARYLAND</b>		
21. I certify that I attended the deceased from <b>April</b> , 19 <b>59</b> , to <b>Dec 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 16</b> , 19 <b>59</b> , and that death occurred at <b>2:30P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. M. Faw Jr.</b>				ADDRESS (Street, city or town, state) <b>Cumberland Md</b>			
DATE SIGNED <b>Dec 16, 59</b>							
PHYSICIAN'S NAME (Type) <b>DR. WYLIE FAW</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Ernest S. Smith</b>			

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ALLISON

HABYLAND

ALLISON

CUMBERLAND

R. WAYS

CUMBERLAND

420 VIRGINIA AVE.

MEMORIAL HOSPITAL

BETWEEN

ATNEY

HERMAN

85

DEC. 20, 1907

WHITE

WILE

U.S.A.

CUMBERLAND, MARYLAND

CARLE HINCLE

GEORGE ATNEY

CUMBERLAND, MARYLAND

MEMORIAL HOSPITAL

WILE FW

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

13160

13174

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland 02</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>129 Mary Street</u>				d. STREET ADDRESS <u>129 Mary Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>Udora</u> Last <u>Balsley</u>				4. DATE OF DEATH Dec. <u>3</u> , 19 <u>59</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u>		11. BIRTHPLACE (State or foreign country) <u>Mt Savage Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Hergott</u>				14. MOTHER'S MAIDEN NAME <u>Laura Beaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Carl M. Balsley 129 Mary St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (c) <u>underlying cause last.</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Dec. 4, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '59</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13161	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>Railroad Street</b>						
3. NAME OF DECEASED (Type or print) First <b>CLIFFORD</b> Middle <b>E.</b> Last <b>BARNES</b>					4. DATE OF DEATH Month <b>12/6/1959</b> Day <b>19</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/16/1906</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer Celanese Corp.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Carles, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Stephen Barnes</b>					14. MOTHER'S MAIDEN NAME <b>Miriam Steele</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>220-10-2353</b>		17. INFORMANT <b>Mrs. Miriam Barnes, Lonaconing, MD</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>890.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carbon Monoxide Poisoning</b> (c) <b>30 Min.</b> DUE TO (c) <b>30 Min.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(MOTHER)</b>										INTERVAL BETWEEN ONSET AND DEATH <b>30 Min.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell asleep in bathtub with gas heater lighted in closed bathroom. Found dead</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>6 00</b> p. m. <b>Dec. 6 1959</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>His Home</b>		20f. (City or town) <b>Lonaconing</b>		(County) <b>Alleg.</b>		(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>W. O. McLane</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED			
EXAMINER'S NAME (Type) <b>W. O. McLane, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			<b>December 6, 1959</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>12/9/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>			22d. LOCATION (City, town, or county) <b>Frostburg, MD.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>					ADDRESS <b>LONA CONING? MD.</b>			24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	





13219

## CERTIFICATE OF DEATH

Reg. Dist. No.

13162

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>?</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Myersdale</u> <u>75x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		d. STREET ADDRESS <u>Rt. # 4</u>	
3. NAME OF DECEASED (Type or print) First <u>Merle</u> Middle <u>Clinton</u> Last <u>Bittner</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 27 1959</u>
9. AGE (In years lost birthday) yrs. <u>9</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>45</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frostburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Merle C Bittner</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Lee Parsons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>9 hrs 45 min</u> (c)		18. INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs 45 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 27</u> , 19 <u>59</u> , to <u>Dec 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>59</u> , and that death occurred at <u>9:16 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>WOMC Lane</u> M.D.		DATE SIGNED <u>Dec 28</u>	
PHYSICIAN'S NAME (Type) <u>WOMC Lane MD</u>		<u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-29-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Skute Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Myersdale Rd # 4 Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. K. Konhaus</u> ADDRESS <u>203 North St Meyersdale</u>		24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18168

CERTIFICATE OF DEATH

18168

18168

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13163

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>48 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15 South Smallwood Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>15 South Smallwood Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Harry Dietrick Bogler</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>December 13 1959</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb 12, 1899</u>	<b>9. AGE</b> (In years last birthday) <u>60</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Driver</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Taxicab</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York State</u>			
<b>13. FATHER'S NAME</b> <u>Andrew Bogler</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Dietrick</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-05-6044</u>		<b>17. INFORMANT</b> <u>15 S. Smallwood Street, Mrs. Mabel Bogler Cumberland, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis with Thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2-3 Hrs.</u>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitarelic</u> M.D.				<b>DATE SIGNED</b> _____			
<b>EXAMINER'S NAME (Type)</b> <u>Benedict Skitarelic, M.D.</u>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>December 13, 1959</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>12/16/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>			
<b>22d. LOCATION (City, town, or county) (State)</b> <u>Cumberland Maryland</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ruth E. Silcox</u> <u>Cumberland Maryland</u>					
<b>24a. REC'D BY REGISTRAR</b> DATE <u>DEC 16 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13220

## CERTIFICATE OF DEATH

Reg. Dist. No.

13164

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>EARL</u> Last <u>BOWEN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Prichard Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Pressman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>216-07-9092</u>	
17. INFORMANT (Daughter) <u>Miss Jean Bowen</u>		Address <u>Frostburg, Md.</u> <u>37 Washington St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Sclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year <u>19 59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 13</u> , 19 <u>59</u> , to <u>Dec 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>59</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>WOMC Lane</u>		ADDRESS (Street, city or town, state) <u>Frostburg</u> DATE SIGNED <u>Dec 14 1959</u>	
PHYSICIAN'S NAME (Type) <u>WOMC Lane</u>		<u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park, Frostburg</u>	22d. LOCATION (City, town, or county) (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bertha H. Montague</u>		ADDRESS <u>25 E. Main, Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

1

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
				</																			



13176

## CERTIFICATE OF DEATH

13165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>75yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>IIO South Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Brown</b>		4. DATE OF DEATH Month Day Year <b>Dec. 6, 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1867</b>
9. AGE (In years last birthday) yrs. <b>92</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>10 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>	
11. BIRTHPLACE (State or foreign country) <b>Hyndman Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Owens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. James W. Wright</b>		Address <b>IIO South St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>191.3</b> DUE TO <b>Uraemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Basal Cell Epithelioma of Face (Very Large)</b> DUE TO (c) <b>10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> , to <b>Dec 6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 6</b> , 19 <b>59</b> , and that death occurred at <b>5:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>236 Va. Ave. Cumberland Md. 12/5/59</b>	
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett</b>		<b>236 Virginia Ave. Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-9-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 18150 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

RECEIVED  
JAN 10 1915

RECEIVED  
JAN 10 1915

<p>1. Name of deceased (Print name and surname)                  _____</p>	
<p>2. Sex (Male or Female)                  _____</p>	
<p>3. Age (In years and months)                  _____</p>	
<p>4. Date of death (Month, day and year)                  _____</p>	
<p>5. Place of death (City, town or village)                  _____</p>	
<p>6. Cause of death (State the immediate cause, and if known, the remote cause)                  _____</p>	
<p>7. Signature of attending physician (Print name and signature)                  _____</p>	
<p>8. Signature of registrar (Print name and signature)                  _____</p>	
<p>9. Signature of informant (Print name and signature)                  _____</p>	
<p>10. Signature of witness (Print name and signature)                  _____</p>	
<p>11. Signature of undertaker (Print name and signature)                  _____</p>	
<p>12. Signature of funeral home (Print name and signature)                  _____</p>	
<p>13. Signature of cemetery (Print name and signature)                  _____</p>	
<p>14. Signature of church (Print name and signature)                  _____</p>	
<p>15. Signature of other (Print name and signature)                  _____</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13166

Reg. Dist. No.

13221

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>50 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 FROSTBURG</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>155 E. MAIN ST.</b>				d. STREET ADDRESS <b>155 E. MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA</b> First <b>ISADORA</b> Middle <b>CASEY</b> Last				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 28, 1903</b>		9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN L. CASEY</b>				14. MOTHER'S MAIDEN NAME <b>MARY GALLAGHER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-38-5618</b>		17. INFORMANT <b>MRS. RITA CLARK, FROSTBURG, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>3533</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Epilepsy -</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden, several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W O Mc Lane</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Dec 7 1959</b>			
EXAMINER'S NAME (Type) <b>W O Mc Lane</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC. 9 '59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAELS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. DURST</b> <i>Joseph R. Durst</i>				ADDRESS <b>FROSTBURG, MD.</b>		24a. REC'D BY REGISTRAR <b>DEC 11 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13167

13228

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3 miles South of Rt. 40</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>			
3. NAME OF DECEASED (Type or print) <b>THOMAS</b> First <b>EDWARD</b> Middle <b>CASSEDY</b> Last <b>JR.</b>				4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1902</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b>	IF UNDER 24 HRS. Hours <b>57</b> Min. <b>57</b>	• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Transit</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Edward Cassedy Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Mary T. Cassedy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-2857</b>		17. INFORMANT Address <b>Mrs Louisa I. Cassedy 3135 Ravenwood Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b> (a), stating the underlying cause last. DUE TO (c) <b>Coronary Sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>-----</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>December 7, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Hafer Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13177

CERTIFICATE OF DEATH

13168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Mineral</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>Rural Keyser 85x-3</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>R.</b> Last <b>Christman</b>				4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1895</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min.		IF UNDER 24 HRS. Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>Charles H. Christman (deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Susan Eckard.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>INFORMANT Patients chart</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO <b>601x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hydronephrosis - Right</b> (c) <b>Multiple Renal Calculi</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>10 yrs ?</b> <b>10 yrs ?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Removal of Right Kidney 16 yrs ago (Left)</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 59</b> to <b>21 Dec 59</b> , that I last saw the deceased alive on <b>21 Dec 59</b> , and that death occurred at <b>11:28 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. Weisman</b> M.D.				ADDRESS (Street, city or town, state) <b>12/21/59</b>			
PHYSICIAN'S NAME (Type) <b>SG Weisman</b>				<b>596 Green St Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>Dec 24, 1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>WAXLER Cem.</b>				22d. LOCATION (City, town, or county) (State) <b>Danville, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. B. Chambers</b>				ADDRESS <b>Keyser, WV</b>			
24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

1910

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Signature of informant

13178

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>Bedford Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROUTE # 1 CLEARVILLE (Mann Twp.)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street or institution) <b>WARWICK &amp; MEMORIAL MEMORIAL HOSPITAL AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARSHALL</b> Middle <b>Dewey</b> Last <b>CLINGERMAN</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 6</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public schools</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CLINGERMAN, ISAAC</b>		14. MOTHER'S MAIDEN NAME <b>MILLER, MARTHA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446 x Uremia</b> DUE TO <b>Generalized Atherosclerosis - Myocardial Infarction</b> DUE TO <b>Hypertension</b> DUE TO <b>Coronary Atherosclerosis - Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>46 days</b> <b>???</b> <b>???</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 12, 1959</b> to <b>Nov 23, 1959</b> , that I last saw the deceased alive on <b>Dec 22, 1959</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel Jacobson</b>		ADDRESS (Street, city or town, state) <b>50 Pershing St., Cumberland, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>DR. SAMUEL JACOBSON</b>		DATE SIGNED <b>12/23/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 26, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>	22d. LOCATION (City, town, or county) (State) <b>Bedford Co., Pa</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lyndon J. Bonner</b>		ADDRESS <b>Everett, Pa.</b>	
24a. REC'D BY REGISTRAR <b>DATE JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18178

Baltimore Co.

PENNSYLVANIA

ALLEGANY

ROUTE 1 CLEARVILLE (Main 100)

5 DAYS  
WINTER & HOSPITAL  
YES

CLEARVILLE

MEMORIAL HOSPITAL

CLINGERMAN

HOSPITAL

DECEMBER

WHITE

MALE

FEBRUARY 2

PENNSYLVANIA

Public Schools

School Teacher

MILLER, MARTIN

CLINGERMAN, LEAN

MEMORIAL HOSPITAL, CLEARVILLE, PENNSYLVANIA

DR. DANIEL JACOBSON

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13170

13229

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>		c. LENGTH OF STAY IN 1b <u>50 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sunnyside</u>				d. STREET ADDRESS <u>Sunnyside</u>			
3. NAME OF DECEASED (Type or print) First <u>Estella</u> Middle <u>Conaway</u> Last <u>Conaway</u>				4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 28, 1889</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chaneysville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. J. Bridges</u>				14. MOTHER'S MAIDEN NAME <u>Roseta Diehl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>E.M. Conaway, Mt. Savage, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (c) <u>666</u> DUE TO (c) <u>666</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 15, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md. RD #1</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey A. Zeigler</u>				ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13179

## CERTIFICATE OF DEATH

Reg. Dist. No.

13171

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>11/26/59</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
f. STREET ADDRESS <b>15 Market Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Samuel</b> Last <b>Cranor</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/1883</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.	11. IF UNDER 24 HRS. Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Samuel Cranor</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT P.O.Box 599</b> Address <b>Cumberland, Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardial degeneration</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Cerebral arteriosclerosis.</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe psychosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/26/59</b> , 19 <b>12/26/59</b> , that I last saw the deceased alive on <b>12/24/59</b> , 19 <b>6:25 PM</b> , and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		DATE SIGNED <b>12/26/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		ADDRESS <b>Cumberland Md</b>	
24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

2516

Altogether

YOUNG, J. L.

1991

62/63/64

02-15-1970

11/11/1919

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1. *Staphylococcus aureus* (ATCC 12228) was grown in tryptic soy broth (TSB) (Difco, Franklin Lakes, NJ, USA) at 37 °C for 24 h. The cells were washed with phosphate buffered saline (PBS) (pH 7.4) and resuspended in PBS. The cell suspension was adjusted to a concentration of  $1 \times 10^8$  CFU/ml.

Robert Carroll

John Smith, Jr.

10.781 10.782

625 205 0 0

250000 1950000 1950000 1950000

22/05/11

92/05/SC

82-15/21

923:6

92/02/51

• *Chlorophyll a*

### Analysis, Synthesis

Dr. James H. McLean

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13180 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13172**

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>696 Fayette St.</b>				d. STREET ADDRESS <b>696 Fayette St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>HAROLD</b> Last <b>DIXON</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>21,</b> Year <b>19 59</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 21, 1927</b>		
9. AGE (In years last birthday) <b>32</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Dixon</b>				14. MOTHER'S MAIDEN NAME <b>Jessie Hall</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 2</b>		17. INFORMANT <b>Harry Dixon</b>		Address <b>Cumberland, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot of Head</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>December 21, 1959</b>		
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 23, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>		
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13173

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EMMASTOWN La Vale</b>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X La Vale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10 Klosterman Ave</b>				/ d. STREET ADDRESS <b>10 Klosterman Ave.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mary Margaret Dressman</b>				<b>4. DATE OF DEATH</b> <b>December 18 1959</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED X</b> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>April 18, 1906</b>		<b>9. AGE</b> (In years last birthday) <b>53</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Midland, Maryland</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>							
<b>13. FATHER'S NAME</b> <b>Augustine Logsdon</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Rose Burkey</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Mrs. Anna M. Michael</b> <b>Address</b> <b>42 Main St. Frostburg, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Gunshot wound of Chest</b>  <b>976X</b> <b>DUE TO</b>            Conditions, if any, which gave rise to immediate cause (b) _____  <b>(c), stating the underlying cause lost.</b> <b>DUE TO</b> _____  <b>(c)</b> _____         </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>Sudden</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) 			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>Benedict Skitarelic</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>Benedict Skitarelic, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>December 18, 1959</b>				<b>DATE SIGNED</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Dec. 21, 1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>SS. Peter &amp; Paul Cemetery</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>Cumberland Maryland</b>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Louis Stein Inc.</i> <b>ADDRESS</b> <b>Cumberland Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DEC 23 '59</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Krasner</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



15-13

18  
13250  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
STATE OF NEW YORK  
COUNTY OF ALBANY

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male	
3. AGE 45		4. DATE OF DEATH 10/15/1918	
5. PLACE OF DEATH New York City		6. CAUSE OF DEATH Pneumonia	
7. MANNER OF DEATH Natural		8. SIGNATURE OF EXAMINER J. J. Jones	
9. SIGNATURE OF WITNESSES J. J. Jones		10. SIGNATURE OF CORONER J. J. Jones	
11. SIGNATURE OF MINISTER OF THE GOSPEL J. J. Jones		12. SIGNATURE OF CLERGYMAN J. J. Jones	
13. SIGNATURE OF JUDGE J. J. Jones		14. SIGNATURE OF SHERIFF J. J. Jones	
15. SIGNATURE OF CLERK J. J. Jones		16. SIGNATURE OF DEPUTY CLERK J. J. Jones	
17. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		18. SIGNATURE OF DEPUTY CLERK J. J. Jones	
19. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		20. SIGNATURE OF DEPUTY CLERK J. J. Jones	
21. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		22. SIGNATURE OF DEPUTY CLERK J. J. Jones	
23. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		24. SIGNATURE OF DEPUTY CLERK J. J. Jones	
25. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		26. SIGNATURE OF DEPUTY CLERK J. J. Jones	
27. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		28. SIGNATURE OF DEPUTY CLERK J. J. Jones	
29. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		30. SIGNATURE OF DEPUTY CLERK J. J. Jones	
31. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		32. SIGNATURE OF DEPUTY CLERK J. J. Jones	
33. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		34. SIGNATURE OF DEPUTY CLERK J. J. Jones	
35. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		36. SIGNATURE OF DEPUTY CLERK J. J. Jones	
37. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		38. SIGNATURE OF DEPUTY CLERK J. J. Jones	
39. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		40. SIGNATURE OF DEPUTY CLERK J. J. Jones	
41. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		42. SIGNATURE OF DEPUTY CLERK J. J. Jones	
43. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		44. SIGNATURE OF DEPUTY CLERK J. J. Jones	
45. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		46. SIGNATURE OF DEPUTY CLERK J. J. Jones	
47. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		48. SIGNATURE OF DEPUTY CLERK J. J. Jones	
49. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		50. SIGNATURE OF DEPUTY CLERK J. J. Jones	
51. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		52. SIGNATURE OF DEPUTY CLERK J. J. Jones	
53. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		54. SIGNATURE OF DEPUTY CLERK J. J. Jones	
55. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		56. SIGNATURE OF DEPUTY CLERK J. J. Jones	
57. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		58. SIGNATURE OF DEPUTY CLERK J. J. Jones	
59. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		60. SIGNATURE OF DEPUTY CLERK J. J. Jones	
61. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		62. SIGNATURE OF DEPUTY CLERK J. J. Jones	
63. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		64. SIGNATURE OF DEPUTY CLERK J. J. Jones	
65. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		66. SIGNATURE OF DEPUTY CLERK J. J. Jones	
67. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		68. SIGNATURE OF DEPUTY CLERK J. J. Jones	
69. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		70. SIGNATURE OF DEPUTY CLERK J. J. Jones	
71. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		72. SIGNATURE OF DEPUTY CLERK J. J. Jones	
73. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		74. SIGNATURE OF DEPUTY CLERK J. J. Jones	
75. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		76. SIGNATURE OF DEPUTY CLERK J. J. Jones	
77. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		78. SIGNATURE OF DEPUTY CLERK J. J. Jones	
79. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		80. SIGNATURE OF DEPUTY CLERK J. J. Jones	
81. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		82. SIGNATURE OF DEPUTY CLERK J. J. Jones	
83. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		84. SIGNATURE OF DEPUTY CLERK J. J. Jones	
85. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		86. SIGNATURE OF DEPUTY CLERK J. J. Jones	
87. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		88. SIGNATURE OF DEPUTY CLERK J. J. Jones	
89. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		90. SIGNATURE OF DEPUTY CLERK J. J. Jones	
91. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		92. SIGNATURE OF DEPUTY CLERK J. J. Jones	
93. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		94. SIGNATURE OF DEPUTY CLERK J. J. Jones	
95. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		96. SIGNATURE OF DEPUTY CLERK J. J. Jones	
97. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		98. SIGNATURE OF DEPUTY CLERK J. J. Jones	
99. SIGNATURE OF DEPUTY SHERIFF J. J. Jones		100. SIGNATURE OF DEPUTY CLERK J. J. Jones	

ALBANY COUNTY



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13181 Item 11 Film G254 1-4-60 et

### CERTIFICATE OF DEATH

13174

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>5yr, 6mo, 23das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Frostburg</b> d. STREET ADDRESS <b>Zihlman</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Myra</b> Middle <b>Evans</b> Last <b>Evans</b>		<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>21</b> Year <b>19 59</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-17-1879</b>
<b>9. AGE</b> (In years last birthday) <b>80</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min. <b>80</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Alleg. Co., Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Thomas B. Evans</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Ann Langford</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <b>Mr. Leslie Steele, Zihlman, Md.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422 Chronic Myocardial Degeneration</b> DUE TO <b>450 General Atherosclerosis</b> (b) <b>592 Chronic Nephritis</b> DUE TO <b>304 Senile (Psychosis)</b> (c)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> ?	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. 19 p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from May 28, 19 54, to December 21, 19 59, that I last saw the deceased alive on December 21, 19 59, and that death occurred at 3:45 P. M. from the causes and on the date stated above.</b>			
<b>ACTUAL SIGNATURE</b> <b>James E. McLean</b>		<b>ADDRESS</b> (Street, city or town, state) <b>49 Greene St.,</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>James E. McLean</b>		<b>DATE SIGNED</b> <b>49 Greene St.,</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12-24-59</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Frostburg Memorial Park Frostburg</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Paul H. Montross</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE DEC 28 '59</b>	
<b>23 E. Main, Frostburg, Md.</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH—BALTIMORE 18

501-751-1111

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McCOOLE</b>	c. LENGTH OF STAY in 1b <b>7 Yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McCOOLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>EVERSTINE</b> Last <b>FAZENBAKER</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 2, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>MARCUS MANUEL FAZENBAKER</b>	
14. MOTHER'S MAIDEN NAME <b>ELIZABETH ELLEN BROADWATER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. NORA O. FAZENBAKER</b> Address <b>McCOOLE, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Ruptured Dissecting Aneurysm of aorta</b> (c) <b>1 hr.</b> DUE TO (a), stating the underlying cause last. (c) <b>1 hr.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>December 1, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>DEC. 4, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PHILLOS CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>WESTERNPORT, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boal</b>		24a. REC'D BY REGISTRAR <b>DATE DEC 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



13182

## CERTIFICATE OF DEATH

13176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>				c. LENGTH OF STAY IN 1b <b>2 HRS.35 MIN.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLOTTE</b> Middle <b>B.</b> Last <b>GARDNER</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>25</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPTEMBER 23, 1903</b>	
9. AGE (In years lost birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
13. FATHER'S NAME <b>HENRY SHOCKEY</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTINE BEAMER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <b>none</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage, severe</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension and arteriosclerosis</b> DUE TO (c) <b>Cardio-vascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>24 Dec.</b> , 19 <b>59</b> , to <b>25 Dec.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>24 Dec.</b> , 19 <b>59</b> , and that death occurred at <b>1:05 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. Alfred Van Ormer</b> M.D.				ADDRESS (Street, city or town, state) <b>122 S. Ontario St. Cumberland, Md.</b>			
PHYSICIAN'S NAME (Type) <b>DR. VAN ORMER</b>				DATE SIGNED <b>28 Dec. 59</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eukhorn</b>				ADDRESS <b>Lonaconing Md.</b>			
24a. REC'D BY REGISTRAR <b>DEC 29 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13185

STATE OF DEATH

ALLEGANY

WYOMING

ALLEGANY

CUMBERLAND, MD.

CUMBERLAND, MD.

MEMORIAL HOSPITAL

CHARTERED

CHARLOTTE

GARDNER

DECEMBER

FEMALE WHITE

DECEMBER 23, 1903

DATE

WYOMING

U.S.A.

NEWLY SHOWN

CHRISTINE BEANS

HONG

MEMORIAL HOSPITAL

CUMBERLAND, MD.

DR. W. W. CROFT

DECEMBER 23, 1903

CUMBERLAND, MD.



13183

## CERTIFICATE OF DEATH

13177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>				c. LENGTH OF STAY IN 1b <b>12 MINUTES</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>BABY</b> Middle <b>GIRL</b> Last <b>GARLITZ</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 21, 1959</b>	
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>IRA A. GARLITZ</b>				14. MOTHER'S MAIDEN NAME <b>MARY LANCASTER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure (Did not expire)</b> 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Erythroblastosis Fetalis (Hydrops)</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>21 Dec</u> , 19 <u>59</u> , to <u>21 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>21 Dec</u> , 19 <u>59</u> , and that death occurred at <u>2:05 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Hanson</u>				ADDRESS (Street, city or town, state) <u>63 Green St. Cumberland</u> DATE SIGNED <u>21 Dec 59</u>			
PHYSICIAN'S NAME (Type) <b>DR. RANSOM</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-22-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. ANNS CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>AVILTON, GARRETT, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Newman Grantville, Md</u>				24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

13183  
CERTIFICATE OF DEATH

ALLEGANY COUNTY, WEST VIRGINIA  
DECEASED: 13 MINUTES  
CLINICAL RECORD NO.

GENERAL HOSPITAL  
FARMINGTON, W. VA.  
FEMALE WHITE  
DOB: DEC. 21, 1908  
U.S.A.  
FARMINGTON, W. VA.  
MRS. A. CARLITZ  
GENERAL HOSPITAL, FARMINGTON, W. VA.

W. R. RAYSON

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13222**  
**CERTIFICATE OF DEATH**

13178

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				d. STREET ADDRESS <b>Washington Ext.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILBUR ELTON GATTENS</b>				4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>1959.</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-15-1900</b>	
				9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Doctor</b>		11. BIRTHPLACE (State or foreign country) <b>Grafton, W.Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Hugh Gattens</b>				14. MOTHER'S MAIDEN NAME <b>Ella Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) Address <b>Frostburg, Md.</b> <b>Mrs. William Day, 141 Mt. Pleasant St.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cor Sclerosis</b>  (c) <b>myocardial Insufficiency</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>4 years</b></p> </div> </div>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec 13</b> , 19 <b>59</b> , to <b>Dec 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 13</b> , 19 <b>59</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Frostburg</b> DATE SIGNED <b>Dec 14 1959</b> ACTUAL SIGNATURE <b>WOMC Lane</b> M.D. <b>MD</b> PHYSICIAN'S NAME (Type) <b>WOMC Lane</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b> <b>23 E. Main, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 18 59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1880</u></p>		<p>4. Age: <u>45</u></p>	
<p>5. Place of birth: <u>Johns Hopkins</u></p>		<p>6. Usual residence: <u>Johns Hopkins</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Date of death: <u>Jan 15, 1925</u></p>	
<p>9. Time of death: <u>10:00 AM</u></p>		<p>10. Place of death: <u>Johns Hopkins</u></p>	
<p>11. Signature of physician: <u>John Doe</u></p>		<p>12. Signature of registrar: <u>John Doe</u></p>	
<p>13. Signature of informant: <u>John Doe</u></p>		<p>14. Signature of witness: <u>John Doe</u></p>	
<p>15. Signature of coroner: <u>John Doe</u></p>		<p>16. Signature of jury: <u>John Doe</u></p>	
<p>17. Signature of jury: <u>John Doe</u></p>		<p>18. Signature of jury: <u>John Doe</u></p>	
<p>19. Signature of jury: <u>John Doe</u></p>		<p>20. Signature of jury: <u>John Doe</u></p>	
<p>21. Signature of jury: <u>John Doe</u></p>		<p>22. Signature of jury: <u>John Doe</u></p>	
<p>23. Signature of jury: <u>John Doe</u></p>		<p>24. Signature of jury: <u>John Doe</u></p>	
<p>25. Signature of jury: <u>John Doe</u></p>		<p>26. Signature of jury: <u>John Doe</u></p>	
<p>27. Signature of jury: <u>John Doe</u></p>		<p>28. Signature of jury: <u>John Doe</u></p>	
<p>29. Signature of jury: <u>John Doe</u></p>		<p>30. Signature of jury: <u>John Doe</u></p>	
<p>31. Signature of jury: <u>John Doe</u></p>		<p>32. Signature of jury: <u>John Doe</u></p>	
<p>33. Signature of jury: <u>John Doe</u></p>		<p>34. Signature of jury: <u>John Doe</u></p>	
<p>35. Signature of jury: <u>John Doe</u></p>		<p>36. Signature of jury: <u>John Doe</u></p>	
<p>37. Signature of jury: <u>John Doe</u></p>		<p>38. Signature of jury: <u>John Doe</u></p>	
<p>39. Signature of jury: <u>John Doe</u></p>		<p>40. Signature of jury: <u>John Doe</u></p>	
<p>41. Signature of jury: <u>John Doe</u></p>		<p>42. Signature of jury: <u>John Doe</u></p>	
<p>43. Signature of jury: <u>John Doe</u></p>		<p>44. Signature of jury: <u>John Doe</u></p>	
<p>45. Signature of jury: <u>John Doe</u></p>		<p>46. Signature of jury: <u>John Doe</u></p>	
<p>47. Signature of jury: <u>John Doe</u></p>		<p>48. Signature of jury: <u>John Doe</u></p>	
<p>49. Signature of jury: <u>John Doe</u></p>		<p>50. Signature of jury: <u>John Doe</u></p>	
<p>51. Signature of jury: <u>John Doe</u></p>		<p>52. Signature of jury: <u>John Doe</u></p>	
<p>53. Signature of jury: <u>John Doe</u></p>		<p>54. Signature of jury: <u>John Doe</u></p>	
<p>55. Signature of jury: <u>John Doe</u></p>		<p>56. Signature of jury: <u>John Doe</u></p>	
<p>57. Signature of jury: <u>John Doe</u></p>		<p>58. Signature of jury: <u>John Doe</u></p>	
<p>59. Signature of jury: <u>John Doe</u></p>		<p>60. Signature of jury: <u>John Doe</u></p>	
<p>61. Signature of jury: <u>John Doe</u></p>		<p>62. Signature of jury: <u>John Doe</u></p>	
<p>63. Signature of jury: <u>John Doe</u></p>		<p>64. Signature of jury: <u>John Doe</u></p>	
<p>65. Signature of jury: <u>John Doe</u></p>		<p>66. Signature of jury: <u>John Doe</u></p>	
<p>67. Signature of jury: <u>John Doe</u></p>		<p>68. Signature of jury: <u>John Doe</u></p>	
<p>69. Signature of jury: <u>John Doe</u></p>		<p>70. Signature of jury: <u>John Doe</u></p>	
<p>71. Signature of jury: <u>John Doe</u></p>		<p>72. Signature of jury: <u>John Doe</u></p>	
<p>73. Signature of jury: <u>John Doe</u></p>		<p>74. Signature of jury: <u>John Doe</u></p>	
<p>75. Signature of jury: <u>John Doe</u></p>		<p>76. Signature of jury: <u>John Doe</u></p>	
<p>77. Signature of jury: <u>John Doe</u></p>		<p>78. Signature of jury: <u>John Doe</u></p>	
<p>79. Signature of jury: <u>John Doe</u></p>		<p>80. Signature of jury: <u>John Doe</u></p>	
<p>81. Signature of jury: <u>John Doe</u></p>		<p>82. Signature of jury: <u>John Doe</u></p>	
<p>83. Signature of jury: <u>John Doe</u></p>		<p>84. Signature of jury: <u>John Doe</u></p>	
<p>85. Signature of jury: <u>John Doe</u></p>		<p>86. Signature of jury: <u>John Doe</u></p>	
<p>87. Signature of jury: <u>John Doe</u></p>		<p>88. Signature of jury: <u>John Doe</u></p>	
<p>89. Signature of jury: <u>John Doe</u></p>		<p>90. Signature of jury: <u>John Doe</u></p>	
<p>91. Signature of jury: <u>John Doe</u></p>		<p>92. Signature of jury: <u>John Doe</u></p>	
<p>93. Signature of jury: <u>John Doe</u></p>		<p>94. Signature of jury: <u>John Doe</u></p>	
<p>95. Signature of jury: <u>John Doe</u></p>		<p>96. Signature of jury: <u>John Doe</u></p>	
<p>97. Signature of jury: <u>John Doe</u></p>		<p>98. Signature of jury: <u>John Doe</u></p>	
<p>99. Signature of jury: <u>John Doe</u></p>		<p>100. Signature of jury: <u>John Doe</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13184

CERTIFICATE OF DEATH

Reg. Dist. No.

13179

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>45 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>1038 Shades Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>William</u> Last <u>Gilford</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24, -89</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>00</u>	IF UNDER 24 HRS. Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Locomotive Engineer Western Md</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. Georgia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>William Gilford</u>				14. MOTHER'S MAIDEN NAME <u>Della Gilford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>214-05-8230</u>		INFORMANT Address <u>Mrs. Clara Gilford 1038 Shades Lane, Cumberland, Maryland</u> Wife			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease - Aortic calcinosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>24 NOV</u> , 19 <u>58</u> to <u>26 DEC</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>26 DEC</u> , 19 <u>59</u> , and that death occurred at <u>9:00</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L Michael Glick</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>126 N. Smallwood Cumberland, MD 12/27/59</u>					
PHYSICIAN'S NAME (Type) <u>Dr. L. Glick</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland (Rural)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>				ADDRESS <u>Cumberland Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

15135

STATE OF DEATH

13135



15135



15135



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13185

## CERTIFICATE OF DEATH

Reg. Dist. No.

13180

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>H.</b> Last <b>GRABENSTEIN</b>				4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1871</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND - CUMBERLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Justus Grabenstein</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Monday</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>			
INFORMANT <b>PT'S CHART</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular fibrillation</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>generalized arteriosclerosis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>5 years</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11-24-</b> , 19 <b>59</b> , to <b>12-1-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-1-</b> , 19 <b>59</b> , and that death occurred at <b>1:45</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 GREENE ST.</b> DATE SIGNED <b>12-2-59</b>							
ACTUAL SIGNATURE <b>L. Brings</b>				M.D. <b>L. BRINGS, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>L. BRINGS, M.D.</b>				<b>57 GREENE ST.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-4-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1918

CERTIFICATE OF DEATH

13182



*[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include:]*

NAME: ...  
AGE: ...  
SEX: ...  
DATE OF BIRTH: ...  
PLACE OF BIRTH: ...  
OCCUPATION: ...  
CAUSE OF DEATH: ...  
DATE OF DEATH: ...  
PLACE OF DEATH: ...  
SIGNATURE: ...  
REGISTRATION NUMBER: ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13186

13181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>22 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>GRIMM</b> Last <b>GRIMM</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18 1930</b>
9. AGE (In years last birthday) <b>29</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Grimm</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Decker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs. Lester's Bennett Cumb Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive ASCV disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Fracture right Hip (non-contributing in this case)</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>see above</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell as a result of cerebral accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:30 Nov. 9 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Cumberland, Alleg. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Dec 1, 1959</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul</b>		22d. LOCATION (City, town, or county) <b>Cumb Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb Md</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DEC 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hanna</b>	

10101

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13182

DATE OF DEATH

PLACE

CAUSE

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## CERTIFICATE OF DEATH

Reg. Dist. No.

13182

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>13187</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>4</b> days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Allegany</b> <b>Maryland</b> b. COUNTY <b>Allegany</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b> <b>Flintstone</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		3. NAME OF DECEASED (Type or print) First <b>Curtis</b> Middle <b>Lee</b> Last <b>Haller</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> , Year <b>1959</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/18/93</b>		9. AGE (In years last birthday) yrs. <b>66</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Phillip Haller(deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Annabelle (deceased)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-10-6292</b>		INFORMANT <b>Patients chart</b>		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> <b>422.1</b> DUE TO <b>Atherosclerotic cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 years</b> (c) <b>4 days</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11 - 58</b> , <b>1958</b> , to <b>12-21</b> , <b>1959</b> , that I last saw the deceased alive on <b>12 - 21</b> , <b>1959</b> , and that death occurred at <b>8:35A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED		ACTUAL SIGNATURE <b>Ralph W. Ballin</b>		M.D. <b>62 Greene St.</b>		<b>12-22-59</b>		PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, Md.</b>		<b>Cumberland, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland (Rural)</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1538



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13188

Reg. Dist. No.

13183

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>70yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland 02</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>910 Gay Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary A. Hamill</u>				4. DATE OF DEATH <u>12</u> Month <u>14</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1866</u>		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u>		11. BIRTHPLACE (State or foreign country) <u>Harper Ferry, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Shewbridge</u>				14. MOTHER'S MAIDEN NAME <u>Mary Finn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-7411</u>		17. INFORMANT <u>Harry Shewbridge</u>		Address <u>527 N. Centre St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease-----</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 Week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>December 15, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli Cumberland</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

13184

13223

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>Lewis</u> Last <u>Hanson</u>		4. DATE OF DEATH Month <u>December</u> Day <u>19th</u> Year <u>1959</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26th, 1878</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-10-5072A</u>		INFORMANT Address <u>78 W. Main Street</u> <u>Miss Ruth Hanson, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left Hemiplegia</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 19, 1959</u> to <u>Dec 19, 1959</u> that I last saw the deceased alive on <u>Dec 19, 1959</u> and that death occurred at <u>3:50 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>WOMC Lane</u>		M.D. <u>Frostburg</u>		ADDRESS (Street, city or town, state) <u>Md</u>		DATE SIGNED <u>Dec 21 1959</u>	
PHYSICIAN'S NAME (Type) <u>WOMC Lane</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13184

13223



*Life*

18

1876



*Correspondence*  
*W. H. H. H.*

X

*W. H. H. H.*  
*W. H. H. H.*  
*W. H. H. H.*

Joseph H. West, Westbury, N.Y.  
1876-77

## CERTIFICATE OF DEATH

Reg. Dist. No.

13185

13189

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>CUMBERLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>31 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART</b>			d. STREET ADDRESS <b>223 FREDRICK STREET</b>		
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ELIZABETH</b> Last <b>HEARTH</b>			4. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>19 59</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1876</b>		9. AGE (In years last birthday) <b>83</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN SHALW</b>			14. MOTHER'S MAIDEN NAME <b>RACHEL ?SHAW</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	INFORMANT <b>CHART</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>450.0</b> IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>1724</b>	(County) <b>1724</b>	(State) <b>1959</b>
21. I certify that I attended the deceased from <b>11/24</b> , 19 <b>59</b> , to <b>12/24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/24</b> , 19 <b>59</b> , and that death occurred at <b>10:10 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>456 N. CENTER STREET</b> DATE SIGNED <b>12/26/59</b>					
ACTUAL SIGNATURE <b>Geo N. Ley Jr.</b>		M.D.			
PHYSICIAN'S NAME (Type) <b>LEO H. LEY M.D.</b>		<b>456 N. CENTER STREET</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/28/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight Cumberland, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 29 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraitsir</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

78101

78101



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13190 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>Life</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>71 Greene St.</b>				d. STREET ADDRESS <b>1 71 Greene St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Edna Heims</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 4, 1890</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frank P. Naughton</b>				14. MOTHER'S MAIDEN NAME <b>Sarah L. Mickel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Frank J. Naughton</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>  <b>-----</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dec. 3, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-7-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Umbria Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Osceola Mills, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 7 '59</b>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13191

CERTIFICATE OF DEATH

13187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maysville</b> <b>85 x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Harry</b> Last <b>Hesse</b>				4. DATE OF DEATH Month <b>12/</b> Day <b>5/</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1887</b>	
9. AGE (In years lost birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
13. FATHER'S NAME <b>Frank Hesse</b>				14. MOTHER'S MAIDEN NAME <b>Linda Goldigen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Clarence Hesse, Maysville, W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>12/3</b> , 19 <b>59</b> , to <b>12/5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/5</b> , 19 <b>59</b> , and that death occurred at <b>1:50 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo H. Ley Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>456 N. Centre St.</b> DATE SIGNED <b>12/7/59</b>			
PHYSICIAN'S NAME (Type) <b>LEO H. LEY JR. M.D.</b>				<b>Cumberland Ind.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/7/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Turner Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cabins, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Baline Schaeffer, Petersburg, W. Va.</b>				24a. REC'D BY REGISTRAR <b>DEC 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hantz</b>	

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MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13188

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Filed 255 12-14-59 et

Reg. Dist. No.

13232

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rawlings</b>		c. LENGTH OF STAY IN 1b <b>years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rawlings</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Residence</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>HISE</b> Last				4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1873</b> <b>April 12, 1873</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Moorefield, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN BARNES</b>				14. MOTHER'S MAIDEN NAME <b>FLORENCE GOODNOW</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>James Hise, Rawlings, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.1</b> DUE TO <b>Arteriosclerotic Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>-----</b> (c) DUE TO <b>-----</b> causing the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured Pelvis, right</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home and became unconscious</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>4:00</b> <b>p. m.</b> <b>Dec. 4</b> <b>1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Rawlings, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>December 7, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bier Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rawlings, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hanna</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 &amp; 9—Film G254-1/15/60-mb

13192

## CERTIFICATE OF DEATH

Reg. Dist. No.

13189

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3/22/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DECEASED (Type or print) First <b>Henry</b> Middle <b>L.</b> Last <b>Hoenicka</b>		4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/29/95</b> <b>4/29/1885</b>
9. AGE (In years last birthday) yrs. <b>64 7/4</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Handy Man</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Hoenicka</b>		14. MOTHER'S MAIDEN NAME <b>Louise Liabrant</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT P. O. Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Chronic Nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe psychosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/22/58</b> , 19__, to <b>12/23/59</b> , 19__, that I last saw the deceased alive on <b>12/22/59</b> , 19__, and that death occurred at __ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Green St.</b> DATE SIGNED <b>12/23/59</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		DATE SIGNED <b>12/23/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumb. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		ADDRESS <b>Cumb. Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>	

13132

Allegany

Underland

3/23/58

Allegany County Jail

Henry

Male White

Height: 5' 10"

Henry Hoonick

Allegany

Underland

637 Columbia Avenue

Hoonick

1/23/58

Maryland

Police Department

P.O. Box 500

Allegany County Jail

12/23/58

12/23/58

12/23/58

12/23/58

Underland, Md.

Dr. James E. Hoonick

13193

CERTIFICATE OF DEATH

Reg. Dist. No.

13190

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 FROSTBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>PINKNEY</b> Last <b>HOLMES</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 9</b>
9. AGE (In years last birthday) <b>65</b>		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min. <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRANSFER CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COURT HOUSE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM P. HOLMES</b>		14. MOTHER'S MAIDEN NAME <b>MARION CAVALIER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216-07-9091</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>501X</b> DUE TO <b>Respiratory Failure due to Spontaneous Right Left Pneumothorax 2 w/</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Severe Bronchitis - Interstitial type</b> (c) <b>104</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia - nephrosclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/22, 19 55</b> to <b>3 Dec, 19 59</b> that I last saw the deceased alive on <b>3 Dec, 19 59</b> , and that death occurred at <b>1:47 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Greene</b>		ADDRESS (Street, city or town, state) <b>59 Greene St</b>	
PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>		DATE SIGNED <b>12/4/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-6-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>		22d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. DURST,</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 7 '59</b>	
ADDRESS <b>FROSTBURG, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

15100

CENTREAST CRPENTH

18193

ALLIANCE

INSTRUMENT

ALLEGANY

PROSTERS

12 DAYS

TUMBERLAND

25 CONRAD STREET

GENERAL A. W. WICK AVE.

DECEMBER 3

ROBERT

PHINNEY

WILLIAM

NOVEMBER 2

WILLIAM

U.S.A.

INSTRUMENT

COUNT HOUSE

WILLIAM P. HOUSE

WORTH CAVARIE

WILLIAM P. HOUSE

333-07-DOSEMERIAL HOSPITAL

*Handwritten notes and signatures, mostly illegible.*

*Handwritten notes and signatures, mostly illegible.*

DR. WILSON

WORTH CAVARIE

12-1-22

WILLIAM

U. S. B. HOUSE - TROSTERS, MI.

13194

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1HR 45 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CUMBERLAND, MARYLAND</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL-MEMORIAL &amp; WARWICK AVES.</b>				d. STREET ADDRESS <b>RT. #4, BOX 132-M. Mexico Farms</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JEROME</b> Middle <b>Joachim</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>14</b> Year <b>19 59</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 12, 1888</b>		9. AGE (In years lost birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Chest Springs, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William F. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Conrad</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Coronary Artery</b> <b>420.1</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>Dec</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 12</b> , 19 <b>59</b> , and that death occurred at <b>3:20A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>133 Virginia Ave</b> DATE SIGNED <b>12/14/59</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>[Signature]</b> PHYSICIAN'S NAME (Type) <b>DR. O. G. HIMMELWRIGHT</b> <b>Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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ALLGARY

CO. ERLAND

100 15 MIL

CANERLAND, HARYLAND

GENERAL HOSPITAL - SIXTH & MARWICK

ST. 10, BOX 132-4, BOXED STARS

GERIC

JOHN IN

DECEMBER 10

NAME WHITE

NOV. 13, 1955

74

HOSPITAL OF THE ARMY, CORPUS CHRISTI, TEXAS, U.S.A.

CHIEF OF THE ARMY

GENERAL HOSPITAL, CANERLAND, CO.

GENERAL HOSPITAL, CANERLAND, CO.

GENERAL HOSPITAL, CANERLAND, CO.

GENERAL HOSPITAL, CANERLAND, CO.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13195

## CERTIFICATE OF DEATH

13192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>715 Maryland Avenue</u>		d. STREET ADDRESS <u>715 Maryland Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Moulton</u> Last <u>Kidd</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>10</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14, 1876</u>
9. AGE (In years last birthday) yrs. <u>82</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John D. Moulton</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Owens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Non e</u>	
17. INFORMANT <u>Mrs. James P. Aaron Jr.</u>		Address <u>92 Braddock Road, Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 yr</u> DUE TO (c) <u>3 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15, 19 59</u> , to <u>Dec 10, 19 59</u> , that I last saw the deceased alive on <u>Dec 8, 19 59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clayton L. Smith</u>		ADDRESS (Street, city or town, state) <u>236 W. Long Cumberland Md</u>	
DATE SIGNED <u>12/12/59</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>		ADDRESS <u>Cumberland Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

13198

13198

<p>1. NAME OF DECEASED                  [Handwritten: <i>John Doe</i>]</p>		<p>2. SEX                  [Handwritten: <i>Male</i>]</p>	
<p>3. AGE                  [Handwritten: <i>45</i>]</p>		<p>4. DATE OF BIRTH                  [Handwritten: <i>Jan 15, 1900</i>]</p>	
<p>5. PLACE OF BIRTH                  [Handwritten: <i>Baltimore, Md.</i>]</p>		<p>6. OCCUPATION                  [Handwritten: <i>Teacher</i>]</p>	
<p>7. MARITAL STATUS                  [Handwritten: <i>Married</i>]</p>		<p>8. DATE OF MARRIAGE                  [Handwritten: <i>June 1, 1925</i>]</p>	
<p>9. NAME OF SPOUSE                  [Handwritten: <i>Jane Doe</i>]</p>		<p>10. DATE OF DEATH                  [Handwritten: <i>Dec 10, 1945</i>]</p>	
<p>11. PLACE OF DEATH                  [Handwritten: <i>Home</i>]</p>		<p>12. CAUSE OF DEATH                  [Handwritten: <i>Heart Disease</i>]</p>	
<p>13. MEDICAL HISTORY                  [Handwritten: <i>None</i>]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Handwritten: <i>Dr. J. Smith</i>]</p>	
<p>15. SIGNATURE OF REGISTRAR                  [Handwritten: <i>John Doe</i>]</p>		<p>16. OFFICIAL USE                  [Blank]</p>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

13193

13233

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13 Camp Ground Road</b>		/d. STREET ADDRESS <b>13 Camp Ground Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AMOS</b> Middle <b>ADAM</b> Last <b>LECHLITER</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>16,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1886</b>
9. AGE (In years last birthday) yrs. <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired millwright</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Tire Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Mineral Co. W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emor Lechlitter</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Largent</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Catherine Lechlitter</b>		Address <b>La Vale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Acute Myocardial Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Hypertensive Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instantly</b> <b>10 y</b> <b>10 y</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/18</b> , 19 <b>55</b> , to <b>12/7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/7</b> , 19 <b>59</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. S. G. Weisman</b>		ADDRESS (Street, city or town, state) <b>59 Greene St.,</b> DATE SIGNED <b>12/17/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. S. G. Weisman</b>		<b>Cumberland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/19/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

13196

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		d. STREET ADDRESS <b>841 BRADDOCK AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH JANE LEGGE</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 21 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 17, 1891</b>
9. AGE (In years lost to day) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Red Cross</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANCIS SMITH</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA SMITH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-38-5491</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> DUE TO <b>Chronic Nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Nephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma head of Pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/12/59</b> , 19, to <b>12/21/59</b> , 19, that I last saw the deceased alive on <b>12/21/59</b> , 19, and that death occurred at <b>9:20 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. J. Williams</b> M.D.		ADDRESS (Street, city or town, state) <b>West Bldg. Cumberland Md 12/21/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. R.J. WILLIAMS</b>		DATE SIGNED <b>12/21/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Beechwoods Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Dubois Penna</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13195

CERTIFICATE OF DEATH

ALLERGY      MARYLAND      ALLERGY

CUMBERLAND      6 DAYS

MEMORIAL HOSPITAL  
MEMORIAL A. MARION AVE.

ELIZABETH JANE      LEGGE      DECEMBER 21      20

WHITE      FEMALE      NOVEMBER 13, 1921      38

U.S.A.      PENNSYLVANIA      U.S.A.

MARTIN SMITH      FRANCIS SMITH

CUMBERLAND, MARYLAND      MEMORIAL HOSPITAL      1



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13197

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN, RT.#3</u> <u>75X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>A.</u> Last <u>LEONARD</u>		4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-16</u>
9. AGE (In years last birthday) <u>13</u> yrs.		10. IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>BRUCE LEONARD</u>		14. MOTHER'S MAIDEN NAME <u>MONICA CALLAHAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>CHART</u>	
17. INFORMANT <u>CHART</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia and Anemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Burns of body</u> (c) <u>10 Years</u> DUE TO (c) <u>10 Years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>Gasoline fire and explosion</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>Ten yrs ago</u> <u>1949</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Berlin Somerset Pa.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Baltimore Cem.</u>		22d. LOCATION (City, town, or county) <u>New Baltimore, Pa.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Ralph Muehl Schellberg, Pa.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Krasa</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registrar prior to burial, cremation, or removal.

PHYSICIAN EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF PHYSICIAN EXAMINER _____		SIGNATURE OF DECEASED _____	
DATE OF EXAMINATION _____		DATE OF DEATH _____	
PHYSICIAN EXAMINER'S NAME _____		PHYSICIAN EXAMINER'S ADDRESS _____	
PHYSICIAN EXAMINER'S CITY _____		PHYSICIAN EXAMINER'S STATE _____	
PHYSICIAN EXAMINER'S COUNTY _____		PHYSICIAN EXAMINER'S ZIP CODE _____	
PHYSICIAN EXAMINER'S LICENSE NO. _____		PHYSICIAN EXAMINER'S EXPIRATION DATE _____	
PHYSICIAN EXAMINER'S SIGNATURE _____		PHYSICIAN EXAMINER'S PRINTED NAME _____	
PHYSICIAN EXAMINER'S ADDRESS _____		PHYSICIAN EXAMINER'S CITY _____	
PHYSICIAN EXAMINER'S STATE _____		PHYSICIAN EXAMINER'S COUNTY _____	
PHYSICIAN EXAMINER'S ZIP CODE _____		PHYSICIAN EXAMINER'S PHONE NO. _____	
PHYSICIAN EXAMINER'S FAX NO. _____		PHYSICIAN EXAMINER'S TELETYPE NO. _____	
PHYSICIAN EXAMINER'S E-MAIL ADDRESS _____		PHYSICIAN EXAMINER'S WEBSITE ADDRESS _____	
PHYSICIAN EXAMINER'S SIGNATURE _____		PHYSICIAN EXAMINER'S PRINTED NAME _____	
PHYSICIAN EXAMINER'S ADDRESS _____		PHYSICIAN EXAMINER'S CITY _____	
PHYSICIAN EXAMINER'S STATE _____		PHYSICIAN EXAMINER'S COUNTY _____	
PHYSICIAN EXAMINER'S ZIP CODE _____		PHYSICIAN EXAMINER'S PHONE NO. _____	
PHYSICIAN EXAMINER'S FAX NO. _____		PHYSICIAN EXAMINER'S TELETYPE NO. _____	
PHYSICIAN EXAMINER'S E-MAIL ADDRESS _____		PHYSICIAN EXAMINER'S WEBSITE ADDRESS _____	



13198

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>16 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>				d. STREET ADDRESS <b>214 SOUTH STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LOTTIE</b> Middle <b>M.</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 21, 1892</b>	
9. AGE (In years last birthday) <b>66 60</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.		IF UNDER 24 HRS. Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>ALFRED TROXELL</b>				14. MOTHER'S MAIDEN NAME <b>MARY WHETZEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Cecum</b> DUE TO (c) <b>8 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 18, 1959</b> , to <b>Dec 18, 1959</b> , that I last saw the deceased alive on <b>Dec 18, 1959</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>D. B. Grove</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>122 S. Centre St., Cumberland, Md., 12-18-59</b>			
PHYSICIAN'S NAME (Type) <b>DR. DONALD B. GROVE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 12-22-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

13198

CERTIFICATE OF DEATH

ALLSPAN

IRVINGLAND

ALLSPAN

CONTERLAND

16 DAYS

CONTERLAND

WHEELER & HOSPITAL WHEELS

514 SOUTH STREET

LOTTIE

M.

WATIN

DECEMBER 1, 1901

514

FEMALE

WHITE

M.

DECEMBER 31, 1901

CONTERLAND, MO.

U. S. A.

ALFRED BROCKELL

MARY BROCKELL

HOSPITAL HOSPITAL - CONTERLAND, MO.

DR. DONALD B. ROY

13199

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>W.</b> Last <b>May</b>				4. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-72</b>	9. AGE (In years lost birthday) yrs. <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Various</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry May (Deceased)</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Patients chart.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/2</b> , 19 <b>59</b> to <b>12/9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/9</b> , 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. M. Schindler</b>				DATE SIGNED <b>12/14/59</b>			
PHYSICIAN'S NAME (Type) <b>B. M. Schindler</b>				ADDRESS (Street, city or town, state) <b>43 Green Street, Cumberland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Maysville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Maysville, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

10151

UNITED STATES DEPARTMENT OF JUSTICE - BUREAU OF PRISONS

CERTIFICATE OF DEATH

13188

1

CO U M ED A T A

House

1971

Various

None

No

GRAND JURY

1971 Dec 1, 1971

1971 Dec 1, 1971



13200

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital-DOA</b>				d. STREET ADDRESS <b>240 Welsh Hill</b>			
3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>McAbee</b> Last <b>McAbee</b>				4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-13-1910</b>		9. AGE (In years last birthday) <b>49 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Recovery Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Ridgely, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George McAbee</b>				14. MOTHER'S MAIDEN NAME <b>Susan Hershberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-9671</b>		17. INFORMANT <b>Mrs. Russell McAbee, 240 Welsh Hill</b>		Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>-----</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 Min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>December 18, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Benedict H. Wroteau</b>				24a. REC'D BY REGISTRAR <b>DEC 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13198  
 BALTIMORE  
 DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: James M. Thompson  
 SEX: Male AGE: 45 YEARS  
 DATE OF BIRTH: 1900 PLACE OF BIRTH: London, England  
 OCCUPATION: Engineer

DECEASED AT: Home PLACE OF DEATH: 1234 Main St, Baltimore, Md.  
 DATE OF DEATH: 10/15/1950 TIME OF DEATH: 10:30 AM  
 CAUSE OF DEATH: Myocardial Infarction  
 MANNER OF DEATH: Natural

SIGNATURE OF EXAMINER: [Signature]

This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy thereof is to be furnished to the family of the deceased.

13198

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13199

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u> c. LENGTH OF STAY IN lb <u>10 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>903 Virginia Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Preston Co.</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tunnelton, W.Va.</u> <span style="float: right;">85X-3</span> d. STREET ADDRESS <u>Tunnelton,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ROY</u> Middle <u>METZ</u> Last <u>METZ</u>				<b>4. DATE OF DEATH</b> Month <u>DECEMBER</u> Day <u>28</u> Year <u>1959</u>			
<b>5. SEX</b> <u>M.</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug. 25, 1897</u>			
<b>9. AGE</b> (In years last birthday) <u>62</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retire Miner</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Coal Mine</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Dodson, Maryland</u>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			<b>13. FATHER'S NAME</b> <u>Charles M. Metz</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Icerena Spiker</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			<b>17. INFORMANT</b> <u>John C. Metz 903 Virginia Ave.</u> Address				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u></span> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis, left</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchiectasis and Emphysema, marked</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>19</u> Hour <u>  </u> o. m. <u>  </u> p. m.		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitarellic</u> <span style="float: right;">DATE SIGNED <u>December 28, 1959</u></span>		<b>EXAMINER'S NAME (Type)</b> <u>Benedict Skitarellic, M.D.</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>12-30-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Camp Chapel Cem.</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Tunnelton W.Va.</u> (State) <u>  </u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James F. Scarpelli Cumberland, Md.</u> ADDRESS					
<b>24a. REC'D BY REGISTRAR</b> <u>DEC 31 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kious</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

PHYSICIAN EXAMINER'S CERTIFICATE OF DEATH

## CERTIFICATE OF DEATH

Reg. Dist. No.

13234

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Scotch Hill</b>				e. STREET ADDRESS <b>Scotch Hill</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Anna Mae Morton</b>			4. DATE OF DEATH <b>12/28/1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/6/1891</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework Own Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Green</b>				14. MOTHER'S MAIDEN NAME <b>Anna Elizabeth James</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Joseph Morton, Lonaconing, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>(HUSBAND)</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the stomach</b> <b>151x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>12</b>	Day <b>28</b>	Year <b>1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1959</b> to <b>Dec. 28, 1959</b> , that I last saw the deceased alive on <b>Dec. 28, 1959</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE <b>George Vash</b>				ADDRESS (Street, city or town, state) <b>27, Main St. Lonaconing, Md.</b>			
PHYSICIAN'S NAME (Type) <b>George Vash</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/31/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b>				ADDRESS <b>LONA CONING, MD.</b>		24a. REC'D BY REGISTRAR <b>DEC 31 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
CERTIFICATE OF DEATH

1. Name of deceased John T. Smith		2. Sex Male		3. Age 45	
4. Date of death Jan 15, 1932		5. Time of death 10:30 AM		6. Place of death Home	
7. Cause of death Heart failure		8. Immediate cause Myocardial infarction		9. Underlying cause Coronary artery disease	
10. Physician's name Dr. J. H. Jones		11. Hospital name St. Mary's Hospital		12. City Baltimore	
13. State Maryland		14. County Baltimore		15. District North	
16. Registrar's name John T. Smith		17. Registrar's address 123 Main St.		18. Registrar's phone 1234	
19. Registrar's signature [Signature]		20. Registrar's title Registrar		21. Registrar's commission 123456	
22. Registrar's seal [Seal]		23. Registrar's stamp [Stamp]		24. Registrar's date Jan 15, 1932	
25. Registrar's initials JTS		26. Registrar's initials JTS		27. Registrar's initials JTS	
28. Registrar's initials JTS		29. Registrar's initials JTS		30. Registrar's initials JTS	
31. Registrar's initials JTS		32. Registrar's initials JTS		33. Registrar's initials JTS	
34. Registrar's initials JTS		35. Registrar's initials JTS		36. Registrar's initials JTS	
37. Registrar's initials JTS		38. Registrar's initials JTS		39. Registrar's initials JTS	
40. Registrar's initials JTS		41. Registrar's initials JTS		42. Registrar's initials JTS	
43. Registrar's initials JTS		44. Registrar's initials JTS		45. Registrar's initials JTS	
46. Registrar's initials JTS		47. Registrar's initials JTS		48. Registrar's initials JTS	
49. Registrar's initials JTS		50. Registrar's initials JTS		51. Registrar's initials JTS	
52. Registrar's initials JTS		53. Registrar's initials JTS		54. Registrar's initials JTS	
55. Registrar's initials JTS		56. Registrar's initials JTS		57. Registrar's initials JTS	
58. Registrar's initials JTS		59. Registrar's initials JTS		60. Registrar's initials JTS	
61. Registrar's initials JTS		62. Registrar's initials JTS		63. Registrar's initials JTS	
64. Registrar's initials JTS		65. Registrar's initials JTS		66. Registrar's initials JTS	
67. Registrar's initials JTS		68. Registrar's initials JTS		69. Registrar's initials JTS	
70. Registrar's initials JTS		71. Registrar's initials JTS		72. Registrar's initials JTS	
73. Registrar's initials JTS		74. Registrar's initials JTS		75. Registrar's initials JTS	
76. Registrar's initials JTS		77. Registrar's initials JTS		78. Registrar's initials JTS	
79. Registrar's initials JTS		80. Registrar's initials JTS		81. Registrar's initials JTS	
82. Registrar's initials JTS		83. Registrar's initials JTS		84. Registrar's initials JTS	
85. Registrar's initials JTS		86. Registrar's initials JTS		87. Registrar's initials JTS	
88. Registrar's initials JTS		89. Registrar's initials JTS		90. Registrar's initials JTS	
91. Registrar's initials JTS		92. Registrar's initials JTS		93. Registrar's initials JTS	
94. Registrar's initials JTS		95. Registrar's initials JTS		96. Registrar's initials JTS	
97. Registrar's initials JTS		98. Registrar's initials JTS		99. Registrar's initials JTS	
100. Registrar's initials JTS		101. Registrar's initials JTS		102. Registrar's initials JTS	

1. Name of deceased  
John T. Smith

2. Sex  
Male

3. Age  
45

4. Date of death  
Jan 15, 1932

5. Time of death  
10:30 AM

6. Place of death  
Home

7. Cause of death  
Heart failure

8. Immediate cause  
Myocardial infarction

9. Underlying cause  
Coronary artery disease

10. Physician's name  
Dr. J. H. Jones

11. Hospital name  
St. Mary's Hospital

12. City  
Baltimore

13. State  
Maryland

14. County  
Baltimore

15. District  
North

16. Registrar's name  
John T. Smith

17. Registrar's address  
123 Main St.

18. Registrar's phone  
1234

19. Registrar's signature  
[Signature]

20. Registrar's title  
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21. Registrar's commission  
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22. Registrar's seal  
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24. Registrar's date  
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Arthur S. Krauss

1921

CERTIFICATE OF DEATH

1921

RECEIVED  
JAN 10 1921  
U.S. DEPT. OF HEALTH  
BUREAU OF VITAL STATISTICS

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Date of death: \_\_\_\_\_

6. Place of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Signature of physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Signature of informant: \_\_\_\_\_

13202

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>22 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lindley</b> Middle <b>Porter</b> Last <b>Nichols</b>		4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/18/76</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>	IF UNDER 24 HRS. Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Silk Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel N. Nichols</b>		14. MOTHER'S MAIDEN NAME <b>Grace Laird</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-12-2335</b>	
17. INFORMANT <b>Henry Heron</b> Address <b>Lonaconing, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>432 Chronic Myocardial Degeneration</b> DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>450 General Arteriosclerosis</b> DUE TO <b>592 Chronic Nephritis</b> (c) <b>304 Severe psychosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 12th, 1959</b> to <b>Dec. 4th, 1959</b> , that I last saw the deceased alive on <b>Dec. 3rd, 1959</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>12/5/59</b>	
PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b>		<b>49 Greene Street, Cumberland, Md.</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 8 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13203

13203

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>20 DAYS</b>		d. STREET ADDRESS <b>22 ARCH STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK &amp; MEMORIAL MEMORIAL HOSPITAL AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>F.</b> Last <b>NORTON</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 15 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>14</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WEST VIRGINIA</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JAMES NORTON</b>		14. MOTHER'S MAIDEN NAME <b>MARY L. WINNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4222</b> DUE TO <b>Thaemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditic Decomposition</b> 3 mo (c) <b>3 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 10, 1959</b> to <b>Dec 8, 1959</b> , that I last saw the deceased alive on <b>Dec 8, 1959</b> , and that death occurred at <b>1:18 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clay J. Durrett</b>		ADDRESS (Street, city or town, state) <b>336 W. 1st Cumberland Md</b> DATE SIGNED <b>7/9/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. JAMES STEGMAYER CLAY DURRETT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-11-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

13203

CENTRAL AVE OF DEATH

13203

ALLEGANY

WARRAND

ALLEGANY

CUMBERLAND

SO DAYS

CUMBERLAND

55 ARCH STREET

WARRICK & MEMORIAL

MEMORIAL HOSPITAL

DECEMBER 8

WORTH

THOMAS

DECEMBER 15 1878

WHITE

MALE

WEST VIRGINIA

DEPARTMENT OF HEALTH

MARY J. WINNER

JAMES WORTH

MEMORIAL HOSPITAL, WARRAND

DR. JAMES WORTH

WARRAND

1878-1879

WARRAND



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13204

Reg. Dist. No.

13204

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>80 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>413 Maryland Ave.</b>				d. STREET ADDRESS <b>413 Maryland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MARGARETE</b> First <b>HELEN</b> Middle <b>O'NEIL</b> Last				4. DATE OF DEATH <b>Dec. 28,</b> Month <b>Dec.</b> Day <b>28</b> Year <b>1959</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 11, 1879</b>		
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Ladies clothing</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas O'Neil</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Moran</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Mrs. Walter Fraley Cumberland, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>CORONARY SCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>December 29, 1959</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/31/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 31 '59</b>		
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13205

### CERTIFICATE OF DEATH

13205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL ** LAVALE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>727 National Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>LOUIS</b> Last <b>ORT</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1881</b> <b>FEB. 4, 1881xx</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY Ort Bros</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Frostburg</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LEWIS ORT (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINA Turner (DECEASED)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>PATIENTS CHART</b>		INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b> <b>8 weeks</b> <b>1 yr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-5-</b> , 19 <b>59</b> , to <b>12-8-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-8-</b> , 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Greene St., Cumberland, Md.</b> DATE SIGNED <b>12/9/59</b>							
ACTUAL SIGNATURE <b>L. Brings M.D.</b>				PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Frostburg Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

30361

## CERTIFICATE OF DEATH

Reg. Dist. No.

13206

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>14 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give address) <b>WARWICK &amp; MEMORIAL MEMORIAL HOSPITAL AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>K. RAR</b> Last <b>PARKER</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 30, 1913</b>
9. AGE (In years and birthday) <b>46 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>MC DONALD, ARCH</b>		14. MOTHER'S MAIDEN NAME <b>SCHELLE, CHRISTINA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-18-1466</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation with terminal cardiac arrest</b> 251X DUE TO <b>Chronic valvular heart disease, with mitral insufficiency, 5 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerosis, inactive</b> DUE TO <b>adenomatous hyperplasia with cholecystectomy 24 Dec 59</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 Dec. 1959</b> to <b>30 Dec. 1959</b> , that I last saw the deceased alive on <b>30 Dec. 1959</b> , and that death occurred at <b>9:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b>		ADDRESS (Street, city or town, state) <b>1225 Centre St, Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>		DATE SIGNED <b>31 Dec 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park, Frostburg, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 5 '60</b>	
23b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13225

CERTIFICATE OF DEATH

Reg. Dist. No.

14350

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>87 Broadway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROBERT</b> First <b>H.</b> Middle <b>PASCOE</b> Last				4. DATE OF DEATH <b>December 20 19 59</b> Month <b>December</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-22-1877</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired maintenance</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beall High School</b>		11. BIRTHPLACE (State or foreign country) <b>Grahamtown, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Man Robert W. Pascoe</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Ellisanwyl</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>213-09-6445</b>			
17. INFORMANT <b>Robert W. Pascoe, 87 Broadway,</b>				Address <b>Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>Several weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec 17, 19 59</b> to <b>Dec 20, 19 59</b> , that I last saw the deceased alive on <b>Dec 17, 19 59</b> , and that death occurred <b>4:40 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>WOMC Lane</b> M.D.				ADDRESS (Street, city or town, state) <b>Frostburg Md.</b> DATE SIGNED <b>Dec 22 1959</b>			
PHYSICIAN'S NAME (Type) <b>WOMC Lane</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boult H. Montecurt</b> ADDRESS <b>23 E. Main, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carthur S. Kraus</b>	

CERTIFICATE OF DEATH

1933

1-1-1933

John W. Lee  
1-1-1933

Dec 17 1932  
John W. Lee  
1-1-1933

13207

## CERTIFICATE OF DEATH

Reg. Dist. No.

13207

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>10/23/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emmanuel</b> Middle <b>Porter</b> Last <b>Porter</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/8/1869</b>
9. AGE (In years lost birthday) yrs. <b>90</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mining</b>	
11. BIRTHPLACE (State or foreign country) <b>Ellerslie, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Leonard Porter</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lowery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>INFORMANT P.O.Box 599</b> Address <b>Cumberland, Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Cerebral arteriosclerosis,</b> DUE TO (c) <b>Chronic Nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Deterioration.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/23/58</b> , 19____, to <b>12/21/59</b> , 19____, that I last saw the deceased alive on <b>12/21/59</b> , 19____, and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Maryland</b> DATE SIGNED <b>12/21/59</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eckhart Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montecant</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
ADDRESS <b>Hafer Funeral Home 23 East Main, Frostburg, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>7 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE E. RUHL</b>		4. DATE OF DEATH <b>DECEMBER 27 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 9 1899</b>
9. AGE (In years last birthday) <b>60</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>QUEEN City Electric MARYLAND, Cumberland U. S. A.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM RUHL</b>		14. MOTHER'S MAIDEN NAME <b>SARAH HANKS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes WW1</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 18. INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/4/59</b> , 19____, to <b>12/27/59</b> , 19____, that I last saw the deceased alive on <b>12/27/59</b> , 19____, and that death occurred at <b>1:45 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Maryland</b> DATE SIGNED <b>12/27/59</b>			
ACTUAL SIGNATURE <b>DR. RICHARD WILLIAMS</b>		PHYSICIAN'S NAME (Type) <b>DR. RICHARD WILLIAMS</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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# STATE OF MARYLAND DEPARTMENT OF HEALTH

13503

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

7 DAYS

CUMBERLAND

251 NORTH CLINTON STREET

WARREN & MEMORIAL  
HOSPITAL

MEMORIAL HOSPITAL

DECEMBER

WILLIAM

WILLIAM

GEORGE

SEPTEMBER 21, 1900

WHITE

WHITE

WILLIAM CITY, ALLEGANY COUNTY, MARYLAND

WILLIAM CITY, ALLEGANY COUNTY, MARYLAND

ALLEGANY

WILLIAM CITY

MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

WILLIAM

WILLIAM

113 South Center St., Cumberland, Md.

DR. RICHARD WILLIAMS

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY

ALLEGANY



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13209

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart HOSpital</b>				d. STREET ADDRESS <b>433 Henderson Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>George E.</b> Middle <b>Schute</b> Last <b>Schute</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 26, 1913</b>		9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.	IF UNDER 24 HRS. Hours <b>46</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celunose Corp of Am</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>William Schute</b>				14. MOTHER'S MAIDEN NAME <b>Clara Marty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-87-3134</b>		17. INFORMANT <b>Mrs. Clara Schute</b> Address <b>Cumbl MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Portal Cirrhosis, Marked; Esophageal Varices</b> Years <b>581.0</b> DUE TO (b) <b>581.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>581.0</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hydrothorax, bilateral; Ascites, marked.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>December 5, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>				ADDRESS <b>Cumbl MD</b>		24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

*[Faint, illegible vertical text]*

1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13210

## CERTIFICATE OF DEATH

Reg. Dist. No.

13210

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>9 HRS. 25 MIN. 02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		d. STREET ADDRESS <b>233 CUMBERLAND STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>SHAFFER</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 28, 1959</b>
9. AGE (In years last birthday) <b>9 25</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS P. SHAFFER</b>		14. MOTHER'S MAIDEN NAME <b>PATRICIA A. KIRK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Failure due to Prematurity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>28 Dec</b> , 19 <b>59</b> , to <b>28 Dec</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>28 Dec</b> , 19 <b>59</b> , and that death occurred at <b>9:47 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmond Ransom</b>		ADDRESS (Street, city or town, state) <b>63 Green St., Cumberland, MD</b>	
DATE SIGNED <b>29 Dec 59</b>			
PHYSICIAN'S NAME (Type) <b>DR. RANSOM</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

2060281XVO

13310

DATE OF BIRTH

13310

ALLIED

ARMY

ALLIED

CUMMINGS

9 MAR 25 1939

CUMMINGS

233 CUMMINGS STREET

MEMORIAL HOSPITAL  
1000 JAIL & MARSHALL AVENUE

30

DECEMBER

SHAW

GIRL

BADY

30

DEC 26 1939

WHITE

FEMALE

U.S.A.

CUMMINGS, MO.

BORN

DECEMBER

PATRICIA A. KIRK

IRVING T. CHARTER

MEMORIAL HOSPITAL, CUMMINGS, MISSOURI

BOY

NO.

*Patricia A. Kirk*

DR. RANSON

233 CUMMINGS STREET

1000 JAIL & MARSHALL AVENUE

MEMORIAL HOSPITAL, CUMMINGS, MISSOURI

## CERTIFICATE OF DEATH

Reg. Dist. No. 13211

13211

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		d. STREET ADDRESS <b>1 Gay Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Raymond</b> Last <b>Shanholtz</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building Cont.</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia, Agustia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Shanholtz</b>		14. MOTHER'S MAIDEN NAME <b>Laura Arnold</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-6788</b>	
17. INFORMANT <b>Mrs. Allie Burge</b>		Address <b>22 Browning St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422 Chronic Hypertension</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>450 General Arteriosclerosis</b> DUE TO (c) <b>581 Cirrhosis of Liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>304 Senile psychosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 21st 1959</b> , to <b>Dec. 29th 1959</b> , that I last saw the deceased alive on <b>Dec. 28th 1959</b> , and that death occurred at <b>1:30 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b>	
PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b>		DATE SIGNED <b>49 Greene St., Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-31-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







13226

## CERTIFICATE OF DEATH

Reg. Dist. No.

13212

## 1. PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

Maryland

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN 1b

6 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

22 Frostburg

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Miners Hospital

d. STREET ADDRESS

40 Maple St.

e. IS RESIDENCE

ON A FARM?

YES ☐ NO ☒

## 3. NAME OF DECEASED (Type or print)

First

Middle

Last

JOHN

CONRAD

SHUCK

## 4. DATE OF DEATH

Month

Day

Year

12

26

19 59

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

Feb. 2, 1890

9. AGE (In years lost birthday)

69 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Service man

10b. KIND OF BUSINESS OR INDUSTRY

Hotel

11. BIRTHPLACE (State or foreign country)

Cresaptown, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob H. Shuck

14. MOTHER'S MAIDEN NAME

Mary Elizabeth McKenzie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

None

220-16-5675

INFORMANT (Daughter)

Address

Frostburg, Md.

Mrs. Mary Arnold, 40 Maple St.,

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO

(c)

Cerebral Hemorrhage  
Left Hemiplegia  
Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

6 Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m.  
p. m.20d. INJURY OCCURRED  
While of work ☐ Not while of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Dec 20, 19 59 to Dec 26, 19 59, that I last saw the deceased alive on Dec 25, 19 59, and that death occurred on Dec 26, 19 59, from the causes and on the date stated above.

ACTUAL SIGNATURE

WOMC Lane M.D.

ADDRESS (Street, city or town, state)

Frostburg

DATE SIGNED

Dec 27

PHYSICIAN'S NAME (Type)

WOMC Lane M.D.

M.D.

1959

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

12-28-59

22c. NAME OF CEMETERY OR CREMATORY

St. Peters Cemetery

22d. LOCATION (City, town, or county)

Westernport

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Reuben H. Montesant

ADDRESS

Hafer Funeral Home

24a. REC'D BY REGISTRAR

DATE DEC 30 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

13238

CERTIFICATE OF DEATH

13238

M

*Handwritten text, likely a signature or name, possibly "Charles H. ..."*

*Handwritten text, possibly a date or location, including "1917" and "New York City"*

13212

## CERTIFICATE OF DEATH

13213

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>60 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>504 Montreal Ave.</b>				d. STREET ADDRESS <b>504 Montreal Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>A.</b> Last <b>Sweitzer</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 7, 1874</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Little Orleans, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John F. Apple</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Slider</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Arch M. Sweitzer, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditis &amp; Scurfification</b> DUE TO <b>3 mon</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 mths</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>57</b> , to <b>Dec 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 1</b> , 19 <b>59</b> , and that death occurred at <b>3:55 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>236 Virginia Ave.</b> DATE SIGNED <b>12-2-1959</b>							
ACTUAL SIGNATURE <b>Clay E. Durrett</b> M.D.				22b. DATE THEREOF <b>Dec. 4, 1959</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Clay E. Durrett, MD</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 4 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13214

13213

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>6/4/1954</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AMY</b> Middle <b>ETHEL</b> Last <b>Tee</b>		4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/2/1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Waitress at Restaurant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Phillip S. Ines</b>		14. MOTHER'S MAIDEN NAME <b>Levinna Trail</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT P.O.Box 599</b> Address <b>Cumberland, Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>General Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/4/54</b> , 19__ to <b>12/30/59</b> , 19__, that I lost saw the deceased alive on <b>12/30/59</b> , 19__, and that death occurred at <b>7:00 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>12/31/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/2/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JAN 5 1960</b>		24b. REGISTRAR'S SIGNATURE <b>James E. McLean</b>	

*Journal of Management Education* 30(6)p.789-804

Alfred

1. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

13276

578 • JGIM

DATE: 1968

Altogether, 20000 copies of the

30, 31

October

194

53

1981/5/1

Penalty: 1 point

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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• *Ch. 1: Introduction*

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REVIEWS

15. 31



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13214

13215

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BERTIE</b> First <b>M.</b> Middle <b>THOMAS</b> Last				4. DATE OF DEATH Month <b>DEC.</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/20/1879</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>FROSTBURG, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>CHARLES SAURBAUGH</b>				14. MOTHER'S MAIDEN NAME <b>JANE ANGIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Arterio-sclerotic cordia</b> DUE TO (b) <b>vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
21. I certify that I attended the deceased from <b>12-8-59</b> , 19 <b>59</b> , to <b>12-13-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-12-59</b> , 19 <b>59</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>122 So. Centre St. Cumberland, Md.</b> <b>12/15/59</b> ACTUAL SIGNATURE <b>W. F. Williams</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

13214

CERTIFICATE OF DEATH

ALLIANCE

MARYLAND

CHANDLER

7 DAYS

LA VILLE, MARYLAND

MEMORIAL HOSPITAL

BERTIE

W.

THOMAS

W.

DEC.

19

59

WHITE

X

5/50/1919

30

HOUSTON

FROSTBURG, MARYLAND

U.S.A.

CHARLES SANDERSON

JANE WILSON

MEMORIAL HOSPITAL, CHANDLER, MD.

none

DR. W. F. WILLIAMS

FROSTBURG, MARYLAND

FROSTBURG, MARYLAND

John A. Miller, Frostburg, Maryland

Frostburg, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13216

13213

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>47 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>918 Maryland Avenue</u>				d. STREET ADDRESS <u>918 Maryland Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Marshall</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 10, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charge hand- Acetate dept</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Celenese</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Flora Dicken</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		(If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>214-07-4608</u>		17. INFORMANT <u>Mrs. Mabel Thomas</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocarditis &amp; Decompensation</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, <u>  </u> Day, <u>  </u> Year <u>  </u> Hour a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Dec 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>59</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clayton S. Silcox</u>				ADDRESS (Street, city or town, state) <u>236 W. Con Cumberland Md</u> DATE SIGNED <u>12/23/59</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>				ADDRESS <u>Cumberland Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF INTERMENT [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF CLERGYPERSON [REDACTED]		NAME OF FUNERAL HOME [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CLERGYPERSON [REDACTED]		SIGNATURE OF FUNERAL HOME [REDACTED]	
DATE OF SIGNATURE [REDACTED]		TIME OF SIGNATURE [REDACTED]		PLACE OF SIGNATURE [REDACTED]	
NAME OF REGISTRAR [REDACTED]		NAME OF CLERK [REDACTED]		NAME OF ASSISTANT CLERK [REDACTED]	
DATE OF REGISTRATION [REDACTED]		TIME OF REGISTRATION [REDACTED]		PLACE OF REGISTRATION [REDACTED]	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER, WHO IS TO SIGN AND RETURN IT TO THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, WITHIN THE PRESCRIBED TIME.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13217

13216

Item 16, Film G-253 12/28/59.cac

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>40 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>320. Resivoir Ave</b>				d. STREET ADDRESS <b>320 Reservoir Ave..</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Harrison</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17 1888</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Constituion Park</b>		11. BIRTHPLACE (State or foreign country) <b>Morgan Co, West Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hines</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW 1.</b>		16. SOCIAL SECURITY NO. <b>220 16 6950</b>		17. INFORMANT Address <b>Ward L, Thompson 320. Resivoir Ave City</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b> DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>December 15, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 18 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Colleen S. Howard</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARSHALL STATE DEPARTMENT OF HEALTH—Baltimore 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH		13218	
NAME OF DECEASED James Harrison Thompson		NAME OF DECEASED James Harrison Thompson	
SEX Male		SEX Male	
RACE White		RACE White	
DATE OF BIRTH March 17 1888		DATE OF BIRTH March 17 1888	
PLACE OF BIRTH Georgetown, Guyana, British Guiana		PLACE OF BIRTH Georgetown, Guyana, British Guiana	
RESIDENCE 350 Reservoir Ave., Baltimore, Md.		RESIDENCE 350 Reservoir Ave., Baltimore, Md.	
OCCUPATION George Thompson		OCCUPATION George Thompson	
CAUSE OF DEATH Yes		CAUSE OF DEATH Yes	
MANNER OF DEATH Coronary Occlusion		MANNER OF DEATH Coronary Occlusion	
MEDICAL HISTORY Coronary Occlusion		MEDICAL HISTORY Coronary Occlusion	
PRESENT ILLNESS Coronary Occlusion		PRESENT ILLNESS Coronary Occlusion	
HISTORY OF PRESENT ILLNESS Coronary Occlusion		HISTORY OF PRESENT ILLNESS Coronary Occlusion	
PHYSICAL EXAMINATION Coronary Occlusion		PHYSICAL EXAMINATION Coronary Occlusion	
LABORATORY EXAMINATIONS Coronary Occlusion		LABORATORY EXAMINATIONS Coronary Occlusion	
POST-MORTEM EXAMINATION Coronary Occlusion		POST-MORTEM EXAMINATION Coronary Occlusion	
SIGNATURE OF PHYSICIAN Coronary Occlusion		SIGNATURE OF PHYSICIAN Coronary Occlusion	
SIGNATURE OF MEDICAL EXAMINER Coronary Occlusion		SIGNATURE OF MEDICAL EXAMINER Coronary Occlusion	
DATE OF DEATH Dec 13 1953		DATE OF DEATH Dec 13 1953	
PLACE OF DEATH 350 Reservoir Ave., Baltimore, Md.		PLACE OF DEATH 350 Reservoir Ave., Baltimore, Md.	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>50 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4 Altamont Terrace</b>			d. STREET ADDRESS <b>1 4 Altamont Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ann</b> Last <b>Topper</b>			4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29 1875</b>		9. AGE (in years last birthday) <b>84</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Wife</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Wright</b>			14. MOTHER'S MAIDEN NAME <b>Hannah Boden</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Allen Boyer, 4. Altamont Terrace</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>Cumberland, Md.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarellic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 12 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	
				22d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



13218

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
1921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Smith		35		Male		White	
Residence		Occupation		Cause of Death		Date of Death	
123 Main St., Baltimore, Md.		Carpenter		Heart Disease		Jan 15, 1921	
Physician		Medical Examiner		Burial Place		Date of Burial	
Dr. J. B. Jones		John Smith		St. Mary's Church		Jan 18, 1921	
Signature of Physician		Signature of Medical Examiner		Signature of Burial Officer		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Death		Place of Burial		Remarks	
Jan 15, 1921		Home		St. Mary's Church			

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13219

13235

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. # 6 Cumberland.</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rt. # 6 Cumberland.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>429 Ave., M. Potomac Park</b>				d. STREET ADDRESS <b>429 Ave., M. Potomac Park</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>TURNER</b> Last <b>TURNER</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b># 31</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 13, 1880</b>		9. AGE (In years next birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>		11. BIRTHPLACE (State or foreign country) <b>Rockingham Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Millard Turner</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Kesner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Harold Turner</b> Address <b>Potomac Park, Cumb. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>----</b>						INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>December 31, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lahmansville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lahmansville, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Keane</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13233

<p>1. NAME OF DECEASED JAMES M. JONES</p>		<p>2. SEX Male</p>	
<p>3. AGE 45</p>		<p>4. RACE White</p>	
<p>5. DATE OF DEATH April 15, 1944</p>		<p>6. PLACE OF DEATH Home</p>	
<p>7. CITY OR TOWN Baltimore</p>		<p>8. COUNTY Baltimore</p>	
<p>9. STREET ADDRESS 1234 North Avenue</p>		<p>10. CITY OR TOWN Baltimore</p>	
<p>11. STATE Maryland</p>		<p>12. ZIP CODE 21201</p>	
<p>13. OCCUPATION Salesman</p>		<p>14. CAUSE OF DEATH Myocardial Infarction</p>	
<p>15. MANNER OF DEATH Natural</p>		<p>16. MEDICAL HISTORY Hypertension, Diabetes</p>	
<p>17. PRESENT ILLNESS Chest pain, shortness of breath</p>		<p>18. TREATMENT Aspirin, Morphine</p>	
<p>19. SIGNATURE OF EXAMINER [Signature]</p>		<p>20. DATE April 15, 1944</p>	

## CERTIFICATE OF DEATH

Reg. Dist. No.

13220

13218

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3/3/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rebecca</b> Middle <b>Wood</b> Last <b>Wathen</b>		4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/10/1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Office Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Uniontown, Pennsylvania U. S. A.</b>	
11. BIRTHPLACE (State or foreign country) <b>Uniontown, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Wathen</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Howser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b>		<b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> <b>592 X</b> DUE TO <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO <b>?</b> (c) <b>Chronic Nephritis</b> DUE TO <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Deterioration</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/3/58</b> , 19____, to <b>12/9/59</b> , 19____, that I last saw the deceased alive on <b>12/8/59</b> , 19____, and that death occurred at <b>4:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Green St.,</b> DATE SIGNED <b>12/9/59</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		DATE SIGNED <b>12/9/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 11, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1

death. Page 4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

13320

CERTIFICATE OF DEATH

13321

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Allegany

Maryland

Allegany

Winchester

3/3/59

Donderland

x

Home #1

Allegany County Jail

29

December 9,

Warren

Good

Rebecca

02

6/10/1974

Female White

Uniontown, Pennsylvania U. S. A.

Retired - Office Worker

Elizabeth Howser  
Uniontown, Pa. 15001  
Allegany County Jail Records

Henry Warren

No

12/6/59

3/2/59

12/6/59

12/7/59

12/7/59

Donderland, Md.

Dr. James E. Nolan

Bureau of Health Statistics, Baltimore, Md.

Uniontown, Pa.